

KENTUCKY MEDICAID PROGRAM
COMMUNITY MENTAL HEALTH MANUAL
POLICIES AND PROCEDURES

1985

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621

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SECTION I - INTRODUCTION

A. INTRODUCTION

This edition of the Kentucky Medicaid Program Community Mental Health Services Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It should assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is **extremely** important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, **Kentucky** 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to Electronic Data Systems (EOS), P.O. Box 2009, Frankfort, KY 40602, or phone (800) 756-7557 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Electronic Data Systems (EDS) provides fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAID PROGRAM

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

The Department for Medicaid Services is bound by both federal and state statutes and regulations governing the administration of the State Plan. Medicaid cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Medicaid Program, Title XIX, is not *to* be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

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B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes payments to providers of services within the scope of covered benefits which have been provided to eligible clients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices which are located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five or six-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committee provide for a broad professional representation to the Advisory Council.

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As necessary, the Advisory Council appoints sub-committees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program clients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the recipient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the recipient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services rendered. If you, as the provider, receive payment from Medicaid before knowing of a third party's liability, a refund of that payment shall be made to Medicaid, and the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

SECTION II - KENTUCKY MEDICAID PROGRAM

Each medical professional is given the choice of whether or not to participate in the Medicaid Program. From those professionals who have chosen to participate, the client may choose the one (1) from whom he wishes to receive his medical care.

When the Department for Medicaid Services makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Stamped signatures are not acceptable. Fraudulent claims are punishable by fine or imprisonment or both.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to clients of this Program shall be on a level of care at least equal to that extended private pay patients, and normally expected of a person serving the public in a professional capacity.

All clients of this Program are entitled to the same level of confidentiality afforded patients not eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

SECTION II - KENTUCKY MEDICAID PROGRAM

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claims shall be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claim shall be paid for services that require, but do not have, prior authorization by the Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and the payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall be attached to the Department and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603

Section 1909. (a) Whoever-

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or

SECTION II - KENTUCKY MEDICAID PROGRAM

fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one (1) year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of any offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in case or in kind--,

SECTION II - KENTUCKY MEDICAID PROGRAM

(A) in return for referring an individual to a **person** for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, ~~or~~ item for which payment may be made in whole or in part under this **title**, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five (5) years or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any **item** or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made **in** whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five (5) years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the **provision** of covered items or services.

SECTION II - KENTUCKY MEDICAID PROGRAM

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, nursing facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five (5) years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, nursing facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five (5) years, or both.

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F. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facility (NF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid recipients, the KenPAC recipients have a green Medicaid card with the name, address, and telephone number of their primary care provider.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Provider

As defined in 902 KAR 20:091 "A Community Mental Health Center shall be a facility which will provide a comprehensive range of accessible, coordinated mental health services including direct patient services and indirect mental health services to the patients of a designated area."

In order to be eligible to participate in the Medicaid Program, a Kentucky community mental health center shall be licensed by the Kentucky Certificate of Need and Licensure Board in accordance with the requirements set forth at 902 KAR 20:091.

Out-of-state providers shall be appropriately licensed to provide community mental health services by the state in which they are located, participate with their State's Title XIX Medicaid Program, and shall meet the Medicaid Program conditions of participation.

B. Services

Of the services required for Community Mental Health Center licensure, the following are reimbursable by Medicaid:

1. Therapeutic Rehabilitation
2. In-Patient Care
3. Outpatient Services
4. Emergency Services
5. Personal Care Home Services
6. Intensive In-Home Services
7. Collateral Services

SECTION III - CONDITIONS OF PARTICIPATION

C. Minimum Staff

Minimum staff requirements for licensure and for Medicaid community mental health center participation are:

1. Center Director: The licensee shall designate an executive director, qualified by training and experience, who shall be responsible for the total program of the center and its affiliates in accordance with the center's written policies and for evaluation of the program as it relates to the clients' needs.
2. Psychiatrist: A board certified or board eligible psychiatrist who may be the clinical director and directly supervises and coordinates all planning functions in the continual development and improvement of the several service elements and provides psychiatric service as indicated in all patient diagnosis and treatment.
3. Licensed Clinical Psychologist: A psychologist licensed in accordance with the requirements set forth in KRS 319, shall provide evaluation and screening services for patients as well as individual and group therapy. This staff member may be utilized to lead diagnostic conferences upon assignment by the center director. The licensed psychologist may provide supervision of certified psychologist(s).
4. Psychiatric Registered Nurse: A psychiatric registered nurse is defined by Medicaid as a registered nurse, licensed in the State of Kentucky with one of the following combinations of education and experience:
 - a. Master of Science in Nursing (MSN) with specialty in psychiatric or mental health nursing. No experience.
 - b. Four-year (4) educational program, with a Bachelor of Science in Nursing (BSN) and a minimum of one (1) year of experience in a mental health setting.

SECTION III - CONDITIONS OF PARTICIPATION

- c. Three-year (3) **educational** program Diploma Graduate with two (2) years of experience in a mental health setting.
- d. Two-year (2) educational program Associate Degree in Nursing (ADN) with three (3) years of experience in a mental health setting.

The psychiatric nurse shall plan and supervise nursing services for psychiatric client care, and coordinate and supervise ~~ser-~~vices rendered by nursing personnel with those rendered by other team administration, other departments, and medical staff in formulating policies for **psychiatric** patient care.

- 5. Psychiatric Social Worker: The psychiatric social worker shall have an MSW degree from an accredited school of social work. The social worker shall develop complete and accurate case histories, assist patient and family in making mental and emotional adjustment to illness, engage in research and teaching activities, mobilize community resources on behalf of patients, and assist in planning for alternate methods of care.
- 6. Medical Records Librarian: A medical records librarian, or capable person to perform the duties of a medical records librarian, shall be responsible for ongoing positive controls, for continuity of client care and the client traffic flow; assure that records are maintained, completed and preserved, and that required indexes and registers are maintained and statistical reports prepared; shall be responsible for seeing that information on clients is immediately retrievable, for the establishment of a central records index, and for all elements of service to provide a constant check **on continuity** of care. In the event that the-designated individual is not a qualified medical records librarian, consultation and technical guidance shall be readily available from a person skilled in health record systems.
- 7. Program Director: - The program director shall be a mental health professional who shall be a psychiatrist, psychologist, psychiatric nurse, or qualified social worker. The program director may also be the executive director.

SECTION III - CONDITIONS OF PARTICIPATION

D. Additional Staff

Additional staff, as defined in Section IV of this manual, whose services may be reimbursable by Medicaid are:

1. Professional Equivalent: A professional equivalent is defined as an individual who by virtue of a combination of education and experience in the Mental Health field is deemed qualified by the Agency and the Professional Equivalency Review Committee of the Department for Medicaid Services to provide mental health services. The general combination of education and experience is as follows:
 - a. Bachelor's Degree, BA, identical field, 3 years full-time equivalent supervised experience;
 - b. Master's degree, identical field, 6 months full-time equivalent supervised experience;
 - c. Doctorate degree, identical field.

Identical fields shall be defined as psychology, sociology, social work and human services as determined by the Professional Equivalency Review Committee. ~~A master's or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.~~

The CMHC may recommend an employee for professional equivalency, but final determination of professional equivalency status is determined by Medicaid.

Please see Appendix IV for the application process for professional equivalency.

SECTION III - CONDITIONS OF PARTICIPATION

2. Mental Health Associate: The mental health associate (MHA) is an individual with a minimum of a bachelor's degree in psychology, sociology, social work, or human services as determined by the Medicaid Program as a mental health field. Only outpatient services provided by the MHA are reimbursable by Medicaid. All outpatient services notes written by the MHA shall be co-signed and there shall be a minimum of a supervisory note once a month. The mental health associate may not provide services to a mentally retarded patient.
3. Certified Psychologist or Psychological Associate: The certified psychologist or psychological associate may be employed by the center to provide covered services under the periodic direct supervision of the licensed psychologist in accordance with KRS 319.
4. Physician: A physician, licensed by the Kentucky Medical Board, may be employed by the Center under the supervision of the psychiatrist to render physical examinations, chemotherapy, emergency and personal care home treatment to clients of the center.

E. Affiliation Agreements

If a center has agreements with other agencies or organizations to provide covered services, these agreements or contracts shall be written and shall include the following:

1. A statement specifying that the resource providing services is in compliance with all existing federal, state, and local laws and regulations governing it.
2. A statement of compliance with the Kentucky Civil Rights Act of 1977, and with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90, which is as follows:

"No person in the United States shall, on the ground of race, color, national origin, sex, handicap or age be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

SECTION III - CONDITIONS OF PARTICIPATION

3. A statement indicating reasonable assurance that medical services shall be provided by the health resource, when the service is deemed necessary by the clients attending physician.
4. A statement indicating that at the time of transfer, or, in case of emergency, as promptly as possible after the transfer an abstract or copies of pertinent clinical and other information necessary to continue the client's treatment without interruption shall be sent to the facility to which the client transfers. The information shall include the following: current medical, mental status and physical findings; diagnosis; brief summary of the course of treatment followed, pertinent social and psychological information; nursing, medication and dietary information useful in the care of the patient; rehabilitation potential, and pertinent information concerning achievements in rehabilitation.
5. A statement indicating **that** clients may be transferred from one element of service to another without delay when appropriate for their treatment.
6. A statement indicating that the staff members treating a client may continue to provide appropriate services during care in other elements of service, when indicated.

A family physician may continue the medical treatment of the client, if desirable.
7. A statement indicating the basis of reimbursement between the health resource and the center.
 - a. A statement indicating the conditions by which the agreement may be terminated by either party.
9. Signatures by individuals **authorized to** execute the agreements on-behalf of-the resources involved.
10. In addition to the above stated criterion; each agreement **with** an-affiliate shall comply with Section 215, Cost Related to: Subcontractors and Affiliate Agreements of the Cabinet **for** Human Resources **Community** Mental Health - Mental Retardation-Reimbursement-Manual.

SECTION III - CONDITIONS OF PARTICIPATION

F. Medical Records

Medical records stress the psychiatric components of the record including history of findings and treatment rendered for the psychiatric condition and shall be evidence of the direct services rendered to individuals by the Community Mental Health Center. A health record shall be maintained for each individual with all entries kept current, dated, entitled according to the service received and signed by the staff members rendering services. Its purpose is to serve as a basis for planning treatment and training for those being served and to provide a means of communicating between all members of the center and its affiliated facilities.

The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

The specific format used for health records is left to the management of the center. It is important, however, that essential information be organized in such a way as to be readily accessible and adequate for the purpose of establishing the current treatment modality and progress of the individual.

Health records maintained on each client receiving services shall contain at least an identification sheet, permission for treatment sheet, the purpose for seeking service, problems, screening information -relative to the problem, pertinent medical, psychiatric and social information disposition (result or treatment plan), assigned status, assigned therapist(s) and staff service notes.

SECTION III - CONDITIONS OF PARTICIPATION

The essential parts of the health record include:

1. IDENTIFICATION

The IDENTIFICATION or INTAKE SHEET shall include: name, social security number, date of intake, home (legal) address, sex, birthdate, religion, next of kin or other responsible party and address, health insurance, referral source and address, personal physician and address, the reason the person is seeking help (presenting problem or diagnosis), the name of the informant and any other information needed to meet state and other center requirements.

2. SCREENING, EVALUATIONS, and DISPOSITION

The extent and type of evaluations obtained at the time of screening are dependent on the problem of the client seeking or being referred for service.

Screening shall include information relative to the client's problem(s) and other personal and health needs. Psychiatric, psychological, psycho-social and other evaluations rendered following screening shall be completed in accordance with accepted professional principles. Immediately following screening, disposition shall be made relative to:

- a. an assigned status
- b. the case is referred for staffing for further discussion and disposition
- or
- c. the case is terminated and referred to an outside source for further service
- or
- d. the case is terminated and further service is not required.

SECTION III - CONDITIONS OF PARTICIPATION

3. STAFFING and TREATMENT PLAN

There shall be staffing conferences following screening to discuss cases, establish diagnoses or clinical impression, recommend additional evaluations and formulate a comprehensive treatment plan which shall include short term and long range goals as well as treatment modalities. The center psychiatrist shall review, approve and sign all treatment plans.

Other cases shall be discussed at staff conferences or with another professional staff member during treatment of individuals for the purpose of reviewing and revising the treatment plan.

There shall be evidence of these conferences or consultations in the health records.

The Treatment Plan shall be reviewed at least once a year and the record shall document the review.

4. HISTORY AND EXAMINATIONS

A complete history, including mental status and treatment rendered shall be required on all Medicaid recipients admitted for treatment by the center.

A current hospital discharge summary containing history information is acceptable or if a history is done outside the center and submitted, it shall be acceptable to the psychiatrist in charge based on content.

5. STAFF NOTES

Staff notes shall be written within one working day of each visit and shall describe the client's symptoms or behavior reaction to treatment, attitude, the therapist's intervention, changes in treatment plan, and need for continued treatment.

SECTION III - CONDITIONS OF PARTICIPATION

All staff notes shall be in chronological order, dated, entitled as to service rendered, have a starting and ending time for the services, and be recorded and signed by the staff person rendering the service with title, i.e. MSW, Psych., Prof. Eq., etc. Family, collateral, telephone and other significant contacts shall also be recorded in the staff notes.

All staff notes shall be recorded and signed by the staff person rendering the service. Initials, typed or stamped signatures are not acceptable.

For therapeutic rehabilitation services, the staff notes of the person delivering the service may be recorded daily, or if the center prefers, as a weekly summary as long as the attendance worksheets are maintained. The weekly summary staff notes shall include a description of the clients' symptoms or behavior, reaction to treatment, attitude, changes in treatment plan, and need for continued treatment. Also a description of activities and how the activities were used to facilitate psychiatric therapy shall also be included in the staff note. The staff note by a paraprofessional shall be co-signed by the supervising professional providing the service.

Staff notes documenting outpatient services provided by a mental health associate shall be co-signed by the supervising professional. There shall be a monthly supervisory note by the professional reflecting consultation concerning the case and the professional's evaluation of services being provided to the client.

6. LABORATORY TESTS AND EXAMINATIONS

Blood and other laboratory tests and examinations shall be performed in accordance with accepted medical practice on all individuals receiving medications prescribed or administered by the center.

SECTION III - CONDITIONS OF PARTICIPATION

7. MEDICATION (CHEMOTHERAPY)

All chemotherapy used in treatment shall be recorded in staff notes and on a special medication form for easy reference and follow-up. A copy of the prescription issued shall be filed in the health record.

Chemotherapy shall be under the direction of a licensed psychiatrist or a licensed physician supervised by a psychiatrist. Prescriptions concerning medication shall not exceed an order for more than five refills.

8. DIAGNOSIS OR CLINICAL IMPRESSION

Diagnoses or clinical impressions shall be in the terminology of the American Psychiatric Association Diagnostic and Statistical Manual (DSM-III and DSM-III-R).

Other intercurrent (physical) diagnoses shall be recorded, followed by information as to where treatment is being received and by whom it is being provided.

Diagnoses shall be recorded in the health record within three visits, in order to receive Medicaid payment.

9. TERMINATION SUMMARY

A termination of summary is required on all clients seen in excess of 3 visits and shall contain a recapitulation of the significant findings and events during treatment, including the final evaluation regarding progress of the client toward goals and objectives set forth in treatment plan, final diagnosis or clinical impression, and condition on termination and disposition.

SECTION III - CONDITIONS OF PARTICIPATION

10. HEALTH RECORD COMPLETION

Active records and those on terminated cases shall be completed promptly.

Evaluations and examinations are to be completed within 3 working days following visits.

Health records of terminated cases are completed within 10 days following termination.

If a case is reopened within ninety days for the same or related problem, reference to the previous case history with an interval note shall suffice.

a. RETENTION OF RECORDS

All health records of terminated clients shall be completed promptly and retained for a period of time determined by the governing authority or in accordance with KRS, which is currently five years.

If a client is transferred or referred to another health care facility for continued care and treatment, a copy or an abstract of his health record shall be forwarded immediately.

In the event of a change in management of a center program, all health records, indexes and registers shall remain the property of the center and be transferred to the new owner.

b. CONFIDENTIALITY OF HEALTH RECORDS

All information contained in the health record is treated as confidential and is disclosed only to authorized persons, authorized Cabinet for Human Resources representatives, or authorized representation of the Federal Government.

SECTION III - CONDITIONS OF PARTICIPATION

The provider shall provide to representatives of the Cabinet for Human Resources requested information to substantiate:

- 1) staff notes detailing service rendered;
- 2) professional rendering service;
- 3) type of service rendered and any other requested information necessary to determine on an individual client and service basis whether services are reimbursable by Medicaid.

Failure of the Community Mental Health Center to provide to Cabinet for Human Resources staff requested documentation shall result in denial of payment for those billed services.

G. Application for Participation

A Community Mental Health Center, being in compliance with the standards as outlined in Title II of Public Law 88-164, licensed in accordance with 902 KAR 20:091 and meeting the requirements of Medicaid as set forth in 907 KAR 1:044, may submit an Application for Participation to the Department for Medicaid Services.

The application shall consist of the following:

1. Participation Agreement (MAP-343, Appendix V)
2. Provider Information Sheet, MAP-344 (Appendix VI)

SECTION III - CONDITIONS OF PARTICIPATION

H. Out-of-State Facility

Kentucky Medicaid reimbursement for outpatient psychiatric services provided in an out-of-state facility is limited to the following conditions as specified in Section 1102 of the Social Security Act; Part 431, Paragraph 431.52, (b) Payment for Services:

"A State plan must provide that the State will furnish Medicaid - to 91) a recipient who is a resident of the State while that recipient is in another State, to the same extent that Medicaid is furnished to residents in the State, when

- (i) Medical services are needed because of a medical emergency;
 - (ii) Medical services are needed because the recipient's health would be endangered if he were required to travel to his State of residence;
 - (iii) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or
 - (iv) It is general practice for recipients in a particular locality to use medical resources in another State; and
- (2) A child for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E of the Act."

The out-of-state facility shall be licensed to provide the community mental health center or outpatient psychiatric services by the state in which it is located, and shall participate as a provider of these services in that state's Title XIX (Medicaid) Program.

An out-of-state facility shall submit a copy of the negotiated participation agreement with their state's Title XIX Program and a copy of that state's Medicaid reimbursement rates for the covered services, in addition to the items listed in paragraph G. Application for Participation, this section.

SECTION III - CONDITIONS OF PARTICIPATION

I. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;
3. Misrepresenting factors concerning a facility's qualifications as a provider;
4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or
5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice shall state:

1. The reasons for the decision;
2. The effective date;
3. The extent of its applicability to participation in the Medicaid Program;
4. The earliest date on which the Cabinet shall accept a request for reinstatement;
5. The requirements and procedures for reinstatement; and

SECTION III - CONDITIONS OF PARTICIPATION

6. The appeal rights available to the excluded party.

The provider receiving the notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
3. Counsel representing the provider;
4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any provider who has received notice from the Cabinet of termination, suspension, denial or nonrenewal of the provider agreement or of suspension from the Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid. Adverse action taken against a provider under Medicare shall be appealed through Medicare procedures.

SECTION IV - COVERED SERVICES

IV. COVERED SERVICES

Psychiatric services provided by participating mental health centers shall be covered through the Community Mental Health element of the Medicaid Program when provided in accordance with Program policy and guidelines as stated in this section. All covered services are listed with applicable procedure codes in Appendix III of this manual.

A. Inpatient Services

Inpatient services provided by a community mental health center shall be designed to provide a therapeutic program for persons requiring full-time care. This shall be utilized only when, and for so long as, no other service of the center is appropriate. The service may be provided in a local general hospital affiliated with the community mental health center, as evidenced by a contract which assures that the appropriate patient services are provided.

1. Initial Inpatient Service

The initial inpatient face-to-face service shall be provided by the center-based psychiatrist before any other inpatient services are payable.

2. Additional Inpatient Services

Following the initial inpatient service, the psychiatrist may determine that the staff psychologist, psychiatric nurse, psychiatric social worker or an equivalent professional may provide therapy for the hospitalized recipient. These services shall be reimbursable when provided under the direction of a plan of care approved by the psychiatrist and recorded in the medical record. Documentation of each service provided shall be recorded, signed and available in the client's center-based record.

CMHC clients who are hospitalized for a diagnosis other than a mental illness diagnosis, may continue to receive outpatient services provided as a part of the client's approved plan of treatment. The psychiatrist does not need to see the client prior to the services being provided.

SECTION IV - COVERED SERVICES

B. Outpatient Services

1. General Information

Outpatient services may be either on-site, which are defined as the CMHC, leased space and donated space, or off-site which includes the client's home, congregate living facility not otherwise reimbursed by Medicaid, school or day care center, senior citizen's center, and Family Resource and Youth Center.

Outpatient services shall be provided on a regularly scheduled basis, with arrangements made for nonscheduled visits during times of increased stress or crisis. The outpatient service shall be the primary point for diagnosis and evaluation of psychiatric problems and the source of referrals to other services and other agencies. All outpatient services shall be provided in accordance with a plan of treatment approved by the center-based psychiatrist.

If outpatient services are provided by a staff member other than the five (5) recognized mental health professionals, the services shall be delivered according to a plan of treatment which has been developed in direct consultation with one (1) of the four (4) principle disciplines and approved and signed by the psychiatrist. Ongoing consultation shall also be maintained with the supervisory staff member throughout the duration of the client's treatment. Staff notes should clearly reflect the input of and supervision by the psychiatrist or supervisory staff member as well as their countersignature.

Outpatient services (with the exception of personal care homes) shall be the only services which may be provided by a staff member other than the five (5) designated mental health professionals (psychiatrist, master social worker, psychologist, psychiatric nurse, and professional equivalent.)

SECTION IV - COVERED SERVICES

2. Individual Therapy

Individual therapy is defined as a therapeutic intervention provided by a qualified mental health center staff for the purpose of reducing or eliminating the presenting problem of the client. This service may include many different modalities of theory and practice. It shall be provided in a face-to-face, one-on-one encounter between the mental health center staff and the client.

3. Group Therapy

Group therapy shall be therapeutic intervention provided by qualified mental health center staff to a group of persons. A group consists of no more than twelve (12) persons. It is usually for a limited time period (generally 1 to 1 1/2 hours in duration.) In group therapy, clients are involved with one another at a cognitive and emotional level.

Group therapy focuses on the emotional and psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers around subjects such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgement. The subject of each group should be relative to all clients participating in the group therapy. Group therapy is distinct from therapeutic rehabilitation services which offer group activities in a therapeutic environment that focus on the development and restoration of the skills of daily living.

Group therapy shall not include physical exercise, recreational, educational, or social activities.

SECTION IV - COVERED SERVICES

4. Family Therapy

Family therapy shall be a therapeutic intervention plan for all members of either the client's immediate household or extended family members who have close **association** with the client. The need for family therapy shall be so stated in the client's plan of treatment. Family therapy services shall be for the benefit of the client and shall be billed under that individual client's MAID number.

5. Collateral Services

Collateral services shall be limited to recipients under the **age** of twenty-one (21), who are clients of the CMHC.

Definition:

Collateral services are face-to-face encounters with parents, legal representative, school personnel or other persons in a position of custodial control or supervision of the client, for the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of care.

Persons in a role of supervision may include day care providers, houseparents, camp counselor, patient's physician, or a social worker with case management responsibility who is not employed by the CMHC.

The services shall be provided by qualified mental health center staff, (psychologist, professional equivalent, psychiatric nurse, social worker, mental health associate) and may include consultation, counseling, assessment, family support on behalf of the child with a focus to accomplish the goals outlined in the plans of treatment. The services may be provided on or off-site. Services delivered to more than one (1) person at the same time shall be billed as if the time were spent with an individual client.

SECTION IV - COVERED SERVICES

The parent or legal representative in a role of supervision of the child shall give written approval for this service. This written approval shall be kept in the recipient's medical record.

A billable unit of service is the actual time spent **face-to-face** delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

6. Intensive In-Home Services

Intensive in-home services shall be limited to children, under age twenty-one **(21)**, who are at risk of placement outside the home into a psychiatric hospital or hospital unit, residential treatment facility or foster care. Risk of placement shall also be interpreted to include the child who has been returned to the home from a placement and whose family placement is likely to be unstable if intensive in-home services are not provided.

Intensive in-home services include the provision of therapeutic services, with the goal of preventing out-of-home placement by teaching problem solving skills, behavior strategies, normalization activities, and other treatment modalities as appropriate.

Billable services shall be face-to-face encounters with the child or his family. Generally, intensive in-home services would be expected to be provided for a duration of four (4) to six (6) weeks for an average of three (3) hours per week of face-to-face encounters with the child and family. However, duration and intensity may vary depending on the individual case and may range **up** to three (3) or even six (6) months, and for more time intensive interventions greater than three (3) hours per week. Family of the child includes those individuals who interact with the child in the household in which the child resides or the family with whom unification is planned.

SECTION IV - COVERED SERVICES

7. Home Visits

Outpatient services may be provided in the patient's place of residence, as long as the place of residence is other than a facility that is eligible for Medicaid participation. Please note that residence in a public institution may preclude eligibility for Medicaid benefits.

Situations in which home visits may be appropriate would include, but not be limited to the following: (1) as part of a beginning assessment in difficult cases, (2) a family crisis in which immediate intervention is needed, (3) as a means of providing outreach in high risk cases, (4) as a means of providing services to homebound individuals, and (5) as a means of helping the client generalize skills to the home setting.

Examples of situations where home visits may be appropriate "as a means of helping a client generalize skills to the home setting" include:

- a. Assisting family members and seriously mentally ill clients to defuse stressful situations which occur in the home by assisting them to practice effective communication techniques in that setting.
- b. Coaching a mentally ill client to initiate social interactions with others in the home setting. When this becomes stressful and precipitates withdrawal or "inappropriate acting out," intervening with the client to practice relaxation or tension reduction techniques.
- c. Intervening with families where domestic violence is a problem to practice fair arguing techniques or to practice face saving withdrawal from an argument.
- d. Coaching family members in carrying out new behaviors aimed at helping a schoolphobic child attend school for several mornings until the family can manage without outside support.

SECTION IV - COVERED SERVICES

- e. Observing family members trying to manage a severely acting out child at a period of the day which is very chaotic for them, (e.g., evening meal time) and intervene in the situation to help them improve their behavior management skills.
- f. Helping a parent and child communicate in the environment where problems are most likely to occur.
- g. Counseling and supporting persons with severe anxiety who are initially too anxious to learn skills outside their home environment.

SECTION IV - COVERED SERVICES

8. Emergency Services

The emergency service of a community mental health center shall provide immediate mental health care on a twenty-four (24) hours a day, seven (7) days a week basis. This service may be provided in many methods.

All components of the emergency services shall be coordinated into a unified program, with assurance that patients receiving emergency services can be readily transferred to other services of the center as their needs dictate.

9. Personal Care Home Services (PCH)

The Community Mental Health Center may request vendor payment for covered services to eligible recipients in personal care homes by a psychiatrist, psychologist, psychiatric nurse, master social worker or an equivalent professional, provided the services are in accordance with the plan of treatment approved by the psychiatrist. Staff notes shall be recorded for EACH VISIT to EACH RESIDENT of the personal care home, and shall be by the covered professional rendering the service. Resocialization or remotivation groups shall be covered services if these are mental health services provided under the direction of a plan of treatment, and individual staff notes document the client's psychiatric symptoms, progress and need for continued therapy.

SECTION IV - COVERED SERVICES

CMHC staff shall also describe the resocialization or remotivation group activities and how these group activities facilitate psychiatric therapy. All mental health services, except individual therapies, that are provided in a personal care home shall be covered as personal care home services.

10. Therapeutic Rehabilitation Services for Adults

A therapeutic rehabilitation program of a community mental health center is a goal oriented service for persons with mental illness which provides a therapeutic program for persons who require less than twenty-four (24) hours a day care but more than outpatient counseling. Therapeutic rehabilitation shall be an effective intervention, the purpose of which is to assure that a person with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn, and work in his own particular environment.

Services shall be designed for the development, acquisition, enhancement, and maintenance of social, personal adjustment, and daily living skills. The focus of all services shall be on helping clients to develop and maintain a health self-esteem. Clients shall be encouraged to retain the fullest possible control of their lives, to set their own rehabilitation goals, and to participate fully in decisions affecting their own lives and future.

Medicaid shall make payment for eligible clients in therapeutic rehabilitation programs if specified by a treatment plan approved and signed by the psychiatrist and if the following requirements are met :

- a. A psychiatrist shall be present in the therapeutic ~~rehabilita-~~tion program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all patients, including the development of the plan of treatment.
- b. The program shall have direct supervision by the psychiatrist, psychologist, psychiatric nurse, master degree social worker ~~or~~ a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct; ongoing supervision and to serve as a source of guidance for other members of the therapeutic team.

SECTION IV - COVERED SERVICES

11. Therapeutic Rehabilitation Services for Children

Children's therapeutic rehabilitation program shall be a goal oriented program for children under age twenty-one (21) who have a mental health diagnosis (DSM III R), and who require more than intermittent outpatient services. The need for this level of intervention shall be identified by the appropriate mental health ~~center staff~~ and shall be indicated in the child's plan of treatment. Therapeutic rehabilitation shall be an effective daily intervention plan to develop, **enhance**, and maintain social, personal adjustment, and daily living skills, as well as the child's self-esteem. These services supplement clinical services such as individual, group, and family **therapy**. ~~The~~ focus of all services shall be to assist the child in **developing** a healthy self-concept and to develop the ability to function in the **community**.

The program shall have the direct supervision of a **psychiatrist**, psychologist, psychiatric nurse, master degree social worker or a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of **guidance** for other members of the therapeutic team.

A psychiatrist shall be present in the therapeutic **rehabilitation** program on a regularly scheduled basis, **at least** monthly, and shall assume clinical responsibility for all clients, **including** the development of a plan of treatment. Treatment plans shall be reviewed and updated by staff at least every three (3) months.

A weekly summary note shall be used to document billable services. Staff notes shall **be written** by the person-providing the service and cosigned, when **appropriate**, by the qualified mental health center staff. The weekly summary note shall reflect the goals and objectives identified in the treatment plan. **In** addition, it shall include an objective description of **the** child's attitude, reaction to treatment, progress, behavior, suggested changes in treatment, and other information as deemed relative to the child's case. A description of the **activities** and how the activities were used to facilitate psychiatric therapy shall also be included.

SECTION IV - COVERED SERVICES

Educational services and needs shall NOT be covered by Medicaid. However, it is recognized that children participating in a therapeutic rehabilitation program have specific educational needs; therefore, the mental health professional and educational system work in a collaborative effort.

Children's therapeutic rehabilitation services may be provided twelve (12) months a year. Individual, group, and family therapies and collateral services may be provided in addition to the therapeutic rehabilitation services.

12. Evaluations, Examinations, Testing

These services shall be diagnostic in nature. Psychiatric evaluations and testing shall be performed only by the psychiatrist. Psychological examinations and testing shall be performed by either the psychologist or psychiatrist. These tests shall be a prelude to therapy. Professional evaluation of all tests shall be handled as administrative costs.

13. Physical Examinations

Physical examinations of clients of the CMHC shall be provided by either the center-based physician or psychiatrist.

14. Services in a Detoxification Setting

The only services covered in a detoxification setting are psychiatric services provided by the center-based psychiatrist.

15. Chemotherapy Services

The medical evaluation of the effectiveness of psychotropic treatments shall be performed by either the physician or psychiatrist.

SECTION IV - COVERED SERVICES

C. Limitations

1. Diagnosis Deferred

Treatment in a Community Mental Health Center for clients with the above "diagnosis" shall be covered if the services are provided by any of the five (5) recognized mental health professionals. Recording of the diagnosis in the client's record by the third visit shall be a requisite for Medicaid payment.

2. Speech Disturbance

Medicaid shall reimburse the community mental health center for the services of a psychiatrist or psychologist to a client with the diagnosis of a Speech Disturbance which is symptomatic of a psychiatric problem. Speech therapy shall be considered outside the scope of Program benefits of the discipline providing speech therapy.

3. Services to Persons with Mental Retardation

When the client's diagnosis is mental retardation, the client shall have an additional psychiatric diagnosis substantiating the need for psychiatric treatment. Diagnoses of developmental disorders, i.e., learning disabilities, shall not be acceptable. Services rendered to persons with mental retardation in need of psychiatric services by a psychiatrist, psychologist, psychiatric nurse, master social worker or a professional equivalent shall be covered by Medicaid when rendered in accordance with the psychiatrist's plan of treatment. The staff note shall document the psychiatric treatment rendered.

SECTION IV - COVERED SERVICES

4. Group Therapy

Group therapy services shall be limited to groups of twelve (12) or fewer per mental health professional. Clients shall be limited to a maximum of three (3) hours of group therapy per day.

5. Individual Therapy

Individual therapy services shall be limited to a maximum of three (3) hours per day.

D. Non-Covered Services

The following services shall NOT be payable by the community mental health element of Medicaid.

1. Speech Therapy.
2. Services provided to residents of nursing facilities.
3. Substance abuse services, including institutional or inpatient care services for patients with a diagnosis of substance abuse.
4. Services to the mentally retarded, without documentation of an additional **psychiatric diagnosis**.

SECTION IV - COVERED SERVICES

5. Psychiatric or Psychological testing for other agencies such as courts or schools, that does not result in the client receiving psychiatric intervention or therapy.
6. Consultation, Educational services, or Collateral Therapy for Ages 21 and Over

Consultation or third party contacts shall be outside the scope of covered benefits. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the plan of care.
7. Telephone calls *or* contacts.
8. Travel time.
9. Field trips and other off-site activities.
10. Recreational, social, and physical exercise activity groups.

These limitations and non-covered services shall be monitored by the Department using a combination of system edits during claims processing and of post-payment reviews and audits. Payment for any services provided outside of the scope of covered benefits shall be **refund-**ed to the Department for Medicaid Services.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

A. In-State Providers

Financial reimbursement for covered community mental health services provided to eligible Medicaid recipients shall be made directly to licensed participating Community Mental Health Centers on the basis of a prospective cost reimbursement system in accordance with the policies and principles set forth by the Cabinet for Human Resources Community Mental Health- Mental Retardation Reimbursement Manual.

Medicaid reserves the right to question services billed to the Program. The medical review staff are qualified professional people bound by confidentiality when evaluating documents from a client's record; and all information submitted as documentation for services rendered shall be handled in a confidential manner.

Billed services that are not substantiated or confirmed by staff notes, signatures, or other supporting documentation when requested **by Program** staff shall be denied for payment on a post-payment **basis**. This also includes services for which staff notes are requested but not provided by a center. If payment for the unsupported services has been made, a refund shall be requested; or the amount owed shall be withheld from a future payment.

SECTION V - REIMBURSEMENT

B. Out-of-State Providers

Medicaid may make payment to out-of-state providers under circumstances described in Conditions of Participation, who are appropriately licensed, participate with their State's Title XIX Medicaid Program, and have met Medicaid conditions of participation for Community Mental Health Services. The payment rate shall be the lower of 1) submitted charges, 2) the facility's rate as set by the State Medicaid agency, or 3) the upper limit in effect for Kentucky providers.

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P. O. Box 2009
Frankfort, KY 40602

ATTN: Financial Services

Failure to refund a duplicate or inappropriate payment may be interpreted as fraud or abuse, and prosecuted.

D. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to a third party when the vendor has prior **knowledge** that a third party may be liable for payment of the services.

In order to identify those clients who may be covered through a variety of health insurance resources, the provider shall inquire if the client meets any of the following conditions:

- If the client is married or working, inquire about possible health insurance through the client or spouse's employer;

- If the client is a minor, ask about insurance the mother, father, or guardian may carry on the client;

SECTION V - REIMBURSEMENT

- In cases of active or retired military personnel, request information about **CHAMPUS** coverage and social security number of the policy holder;
- For people over 65 or disabled, seek a Medicare HIC number;
- Ask if the client has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.

Examine the client's MAID card for an insurance code. If a code indicates insurance coverage, question the client further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

- A - Part A, Medicare only
- B - Part B, Medicare only
- C - Both Parts A and B Medicare
- D - Blue Cross/Blue Shield
- E - Blue Cross/Blue Shield/Major Medical
- F - Private medical insurance
- G - **Champus**
- H - Health Maintenance Organization
- J - Other or unknown
- L - Absent Parent's insurance
- M - None
- N - United Mine Workers
- P - Black Lung

E. Other Third Party Coverage

If the client has third party resources, then the provider shall obtain payment or rejection from the third party before Medicaid can be billed. When payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and attach a copy of the explanation of benefits to the claim form. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim.

SECTION V - REIMBURSEMENT

Exceptions:

*If the other insurance company has not responded within 120 days of the date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form (Appendix XIII) to:

EDS
P. O. Box 2009
Frankfort, KY 40602

ATTN: TPL Unit

*If proof of denial for the same client for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he contacted XYZ insurance company and spoke with an agent to verify that the client was not covered, can also be attached to the Medicaid claim.

If you have any questions, please write to EDS, P. O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 756-7557.

F. Medicare, Title XVIII, Coverage

Title XVIII, Medicare, has first liability for clients who have both Medicare and Medicaid coverage. Community Mental Health Center claims for services by a physician or psychiatrist to the clients with dual coverage, shall be filed with the Medicare fiscal intermediary before being submitted to EDS.

Upon receipt of the Medicare payment, the amount received shall be entered in the appropriate block on the billing form, HCFA-1500 (12/90), and submitted to EDS with the Medicare Explanation of Benefits attached.

SECTION V - REIMBURSEMENT

When the Medicare allowable amount is applied to the client's deductible liability and therefore no payment is received, the Explanation of Medicare Benefits is to be attached to the HCFA-1500 (12/90) and submitted to EDS.

If Medicare denies a service, or states the over-65 patient to be ineligible for Medicare coverage, a copy of the statement of denial shall be attached to the HCFA-1500 (12/90) invoice and submitted to EDS.

G. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment shall be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as, the names of attorneys, other involved parties or the client's employer to the claim when submitted to EDS for Medicaid payment.

H. Claims Over Twelve Months Old

Claims with service dates more than twelve (12) months old shall be considered for processing only with appropriate documentation such as one or more of the following: Remittance statements which verify timely filing, backdated MAID cards (the words "backdated card" should be written on the claim form and on the copy of the backdated MAID card), Social Security documents, Action Sheets, Return to Provider Letters, Medicare EOMB's etc. Without such documentation, claims over 12 months old shall be denied.

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General Billing Information

The Health Insurance Claim Form (HCFA-1500), (12/90) is used to bill for services provided by a Community Mental Health Center to eligible Medicaid recipients.

The original of the two part invoice set shall be submitted to EDS. The yellow copy of the invoice shall be retained by the provider as a record of claim submittal.

Invoices shall be mailed to:

E. D. S.
P. O. Box 2018
Frankfort, Kentucky 40602

Claims for covered services to eligible Title XIX recipients shall be received by EDS within twelve (12) months of the date of service.

Claims with a service date more than twelve (12) months old can be considered for processing only with appropriate documentation such as one or more of the following: Remittance Statements which verify timely billing, backdated MAID cards, Social Security documents, correspondence describing extenuating circumstances, action sheets, Return to Provider Letters, Medicare Explanation of Medicare Benefits, etc.

All claims shall be sent to EDS for processing.

B. General Billing Clarification

1. A separate billing form shall be used for each client.
2. A separate line shall be used for each service billed.

SECTION VI - COMPLETION OF INVOICE FORM

3. An individual procedure code shall be payable only one (1) time per date of service. Units will denote the time involved. However, if a person receives more than one different service per date, both may be billed.
4. The center's usual and customary charges shall be entered for all services billed.
5. Units of service shall be entered for each service billed.
6. Units of service shall denote time involved in delivering each procedure. Charges shall be as **follows**: total of units rendered times usual and customary charge per unit.
7. Therapeutic Rehabilitation is billed by the procedure code of the professional in charge. Do not bill for any additional support staff.

C. Completion of the Health Insurance Claim Form

An example of the Health Insurance Claim Form (HCFA-1500), (12/90) may be found in Appendix XIX. Instructions for the proper completion of this form are presented below.

IMPORTANT: The client's Kentucky Medical Assistance Identification Card should be carefully checked to see that the client's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. You shall not be paid for services rendered to an ineligible person. MAID cards are issued monthly.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
2	Patient's Name Enter the client's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card.
9A	Insured's Policy or Group Number Enter the client's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID cards.
10B, C	Accident Check the appropriate block if treatment rendered was necessitated by some form of accident.
11	INSURED'S POLICY GROUP OR FECA NUMBER Complete if the client has <i>any</i> kind of private health insurance that has made a payment, other than Medicare.
11C	INSURANCE PLAN NAME OR PROGRAM NAME Enter the insurance name and program name.
21	Diagnosis Code Enter the appropriate DSM-III R diagnosis code for the diagnosis which the services billed are being rendered as treatment. Enter any additional diagnosis for which services billed on this statement are being rendered as treatment or the condition of the patient that is secondary to the treated diagnosis, e.g., Mental Retardation.
24A	Date of Service Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, July 1, 1993 would be entered as 07-01-93 .

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
24B	Place of Service Enter the appropriate two digit place of service code identifying where the services were performed.
24D	Procedures, Services, or Supplies CPT/HCPCS Enter the five (5) digit procedure code-which identifies the service provided. All covered procedures are listed with corresponding procedure code in Appendix III of this manual. MODIFIER Enter the one (1) digit code identifying the type of professional who provided the service. Then enter the employee's identifying number, which may be up to four (4) digits.
24E	Diagnosis Code Indicator Transfer "1", "2", "3", or "4" from field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.
24F	Procedure Charge Enter your usual and customary charge for the service rendered.
24G	Days or Units Enter the number of units this procedure was provided on this date of service.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
24H	EPSDT Family Plan Enter an "E" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment examination. Enter an "F" if the treatment rendered was a direct result of a Family Planning examination.
26	Patient's Account No. Enter the client account number if desired. EDS will key the first seventeen or fewer digits. This number will appear on the Remittance Statement as the invoice number.
28	Total Charge Enter the total of the individual charges listed in column 24F.
29	Amount Paid Enter the amount received by private insurance. DO NOT INCLUDE Medicare. If private insurance made a payment, block 11 and 11c shall be completed.
30	Balance Due ENTER THE AMOUNT RECEIVED FROM MEDICARE. If there is no Medicare payment, no entry is required.
31	Signature/Invoice Date The actual signature of the provider (not a facsimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.
33	Provider Number Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit Medicaid provider number.

SECTION VI - COMPLETION OF INVOICE FORM

D. Billing Instructions for Clients with Medicare

If the Title XIX client has applicable coverage under Title XVIII, Medicare, all billings for CMHC services provided by a physician, psychiatrist or psychologist shall be filed with the Medicare fiscal intermediary before Medicaid can be billed.

1. If Medicare has made a payment for services, complete the HCFA-1500 (12/90) in the same manner as a regular billing, entering the amount received from Medicare in Block #30. Attach a copy of the Explanation of Medicare Benefits (EOMB) to the HCFA-1500 (12/90), and mail to EDS.
2. If Medicare does not make a payment, due either to the allowable amount being applied to the recipient's deductible liability, or a Medicare denial, attach a copy of the EOMB or the statement of denial to the HCFA-1500 (12/90) and submit to EDS.

E. Billing instructions for clients with Health Insurance Coverage (Excluding Medicare)

1. If a third party carrier has made a payment, enter the amount received in Block #29 of the HCFA-1500 (12/90) and attach the Explanation of Benefits to the claim. If payment was denied, attach a copy of the denial to the HCFA-1500 (12/90).

F. Electronic Claims Submission

Providers submitting claims electronically shall have on file a MAP-380 "Provider Agreement Addendum". If using a billing agency, a MAP-246 "Agreement between the Kentucky Medical Assistance Program and the Electronic Medical Billing Agency" shall be on file.

Security information shall also be assigned by EDS to each provider before claims can be submitted electronically.

SECTION VII - REMITTANCE STATEMENT

VII. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of ~~those~~ **claims** EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by Medicaid with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by Medicaid with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that were not processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the **year-**to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the client's last name.

SECTION VII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix IX P.1. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT
FOR COMMUNITY MENTAL HEALTH SERVICES

ITEM

INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS
CLAIM SVC DATE	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge)

SECTION VII - REMITTANCE STATEMENT

AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid program for services on this claim
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim
EOB	For explanation of benefit code, see back page of Remittance Statement
LINE NO.	The number of the line on the claim being printed
PS	Place of service code depicting the location of the rendered service
PROC	The procedure code in the line item
QTY	The number of procedures/supply for that line item charge
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all denied claims and indicates the EOB code explaining the reason for each claim rejection. Appendix IX P.2

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

SECTION VII - REMITTANCE STATEMENT

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix IX P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims in Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix IX P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID OR
DENIED

the total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity

AMOUNT PAID

the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity

SECTION VII - REMITTANCE STATEMENT

WITHHELD AMOUNT	the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	the dollar amount that appears on the check
CREDIT AMOUNT	the dollar amount of a refund that a provider has sent-in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount)
NET 1099 AMOUNT	the total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement shall have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix IX P. 5).

SECTION VIII - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

TYPE OF INFORMATION REQUESTED	TIME FRAME FOR INQUIRY	MAILING ADDRESS
Inquiry	6 weeks after billing	EDS P. O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit

Adjustment	Immediately	EDS P. O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
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Refund	Immediately	EDS P. O. Box 2009 Frankfort, KY 40602 ATTN: Financial Services
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TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Inquiry	<ol style="list-style-type: none">1. Completed Inquiry Form2. Remittance Advice <i>or</i> Medicare EOMB, when applicable3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

SECTION VIII - GENERAL INFORMATION - EDS

TYPE OF
INFORMATION
REQUESTED

NECESSARY INFORMATION

Adjustment

1. Completed Adjustment Form
2. Photocopy of the claim in question
3. Photocopy of the applicable portion of the R/A in question

Refund

1. Refund Check
2. Photocopy of the applicable portion of the R/S in question
3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Client's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-756-7557 (within Kentucky)
- Local (502)227-2525

SECTION VIII - GENERAL INFORMATION - EDS

C. Filing Limitations

New Claims 12 months from date of *service*

Medicare/Medicaid
Crossover Claims 12 months from date of service

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and shall proceed with claims processing.

Third-Party
Liability Claims 12 months from date of service

NOTE: If the other insurance company has not responded within 120 days of date of service, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

Adjustments 12 months from date the paid claim appeared on the R/A

SECTION VIII - GENERAL INFORMATION - EDS

D. Provider Inquiry Form

The Provider Inquiry form shall be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form shall be completed for each status request.) The Provider Inquiry Form shall be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-756-7557 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry may be attached. EDS shall enter their response on the form and the yellow copy shall be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of Medicaid claim forms, Adjustment forms, or any other document required by Medicaid.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION VIII - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provide Inquiry form:

FIELD NUMBER	INSTRUCTIONS
1	Enter your 8-digit Kentucky Medicaid Provider Number. If you are a Medicaid certified clinic, enter your 8 digit clinic number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and date of the inquiry.

SECTION VIII - GENERAL INFORMATION - EDS

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. A CORRECTED COPY OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A SHALL BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

FIELD NUMBER	DESCRIPTION
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

SECTION VIII - GENERAL INFORMATION - EDS

FIELD NUMBER	DESCRIPTION
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

SECTION VIII - GENERAL INFORMATION - 'EDS

- F. The Cash Refund Documentation form shall be completed with a provider sends a refund check. The completed form and a copy of the **reimittance** advice page showing the paid claim being refunded should accompany the check. Please mail to the following address:

EDS
P. O. Box 2009
Attn: Financial Services
Frankfort, KY 40602

If a check is sent without the Cash Refund Documentation form, your check shall not be posted to a specific claim. Such action would not reflect the refund being made for a particular claim, possibly leaving the provider responsible for another refund at a later date. If there are any questions **concerning** the form, **please** call the Provider Relations-Unit at 1-800-756-7557 or 1-(502)-227-2525.

FIELD NUMBER	DESCRIPTION
1	Enter check number
2	Enter amount of the check
3	Enter provider name, number and address
4	Enter name of recipient on claim being re-funded
5	Enter recipient's Medicaid identification number (10 numeric digits)
6	Enter "From Date of Service" on claim being refunded
7	Enter "To Date of Service" on claim being refunded
8	Enter date of the Paid Remittance Advice on which the claim appears

SECTION VIII - GENERAL INFORMATION - EDS

9

Enter 13-digit **Internal** Control Number (ICN) of the particular claim for which you are refunding. This is a list on the "Paid Claims" page of your remittance advice. (If several **ICN's** are to be applied to one check, they can be listed on the same form only if they have the same reason for refund explanation.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR HUMAN RESOURCES

DEPARTMENT FOR MEDICAID SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and comprehensive orthodontics are also available to recipients under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

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EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-second birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Examination
- Growth and Development Assessment
- Hearing, Dental, and Vision Screenings
- Lab tests as indicated
- Assessment or Updating of Immunizations

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

DEPARTMENT FOR MEDICAID SERVICES

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aid services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes **disposable** medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be **preauthorization** by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medically necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age one (1) in any hospital and recipient under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid.

DEPARTMENT FOR MEDICAID SERVICES

OUTPATIENT SERVICES

Benefits of the Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

DEPARTMENT FOR MEDICAID SERVICES

LONG TERM CARE FACILITY SERVICES

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

- A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision. *
- B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources. **

*Need for the intermediate level of care must be certified to a PRO.

**Need for the ICF/MR/DD level of care must be certified by a PRO.]

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DEPARTMENT FOR HUMAN RESOURCES

DEPARTMENT FOR MEDICAID SERVICES

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

MENTAL HOSPITAL SERVICES

Reimbursement is available for inpatient psychiatric services provided to Medicaid recipients under the age to twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

- Outpatient Services
- Therapeutic Rehabilitation
- Emergency Services
- Inpatient Services
- Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health centers and possibly avoid hospitalization. There are fourteen (14) major centers, with satellite center available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

DEPARTMENT FOR MEDICAID SERVICES

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up post partum visits within four (4) to six (6) weeks of the delivery date.

NURSE PRACTITIONER

Services by an Advanced Registered Nurse Practitioner shall be payable if the services provided is within the scope of licensure.

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medicaid Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities.

Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization be covered for payment through the Drug **Preauthorization** Program. In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

CABINET FOR HUMAN RESOURCES
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PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs, selected vaccines and Rhogam), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

Certain types of office exams, such as comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

DEPARTMENT FOR MEDICAID SERVICES

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional **supervision**.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health **care** facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers **include** medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal free-standing dialysis center service benefits include renal dialysis, certain supplies and home equipment.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR HUMAN RESOURCES

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RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasized preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SPECIAL SERVICES PROGRAM

Considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their twenty-first birth month. All services shall be prior authorized by the Department for Medicaid Services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

DEPARTMENT FOR MEDICAID SERVICES

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

TARGETED CASE MANAGEMENT SERVICES - ADULT

Case Management services provided to recipients 18 years of age or older with chronic mental illness who need assistance in obtaining medical, educational, social and other support services.

TARGETED CASE MANAGEMENT SERVICES - CHILDREN

Case Management services provided to SED children who need assistance in obtaining medical, educational, social and other services.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facilities services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a **continuous** basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment facility services shall be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES

****SPECIAL PROGRAMS****

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only shall be covered under KenPAC. The recipient shall choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

[AIS/MR:] The Alternative Intermediate Services for the ~~[/]~~**Mentally Retarded[ation]** (AIS/MR) home- and community-based services program [project] provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). [Community mental health centers arrange for and provide these services.]

DEPARTMENT FOR MEDICAID SERVICES

HOME AND COMMUNITY BASED WAIVER SERVICES

[HCB:] A home-and community-based services program [project] provides Medicaid coverage for a broad array of home-and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

SPECIAL HOME-AND COMMUNITY-BASED SERVICES MODEL WAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits shall be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office of information about making application. Form most program, a relative or other interested party may make application for a person unable to visit the office.

In addition to the program administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) programs also receive Medicaid through the Medicaid Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to **recipients** with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals who original card is lost or stolen. The recipient shall report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. ● From date first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	REL.
ELIGIBILITY PERIOD FROM: 08-01-90 TO: 07-01-90 CASE NUMBER 037 C 000123456		Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
CASE NAME AND ADDRESS ISSUED DATE: 05-27-90 Janesmith 400 Block Ave. Frankfort, KY 40601 ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS SEE OTHER SIDE FOR SIGNATURE MAP 520 REV 1/80						

Date card was issued

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For Kentucky Medicaid Program Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid Program benefits.

Data of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

WHITE CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in 'Ins.' block

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES																		
<p>This card certifies that the person(s) listed herein is /are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p>Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621-0001</p>	<ol style="list-style-type: none">1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.4. If you have questions, contact your eligibility worker at the county office.5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.																		
<p>Insurance Identification</p> <table border="0"><tbody><tr><td>A-Part A, Medicare Only</td><td>F-Private Medical Insurance</td></tr><tr><td>R-Part A, Medicare Premium Paid</td><td>G-Champus</td></tr><tr><td>B-Part B/Medicare Only</td><td>H-Health Maintenance Organization</td></tr><tr><td>C-Both Parts A & B Medicare</td><td>J-Unknown</td></tr><tr><td>S-Both Parts A & B Medicare Premium Paid</td><td>K-Other</td></tr><tr><td>D-Blue Cross Blue Shield</td><td>L-Absent Parent's Insurance</td></tr><tr><td>E-Blue Cross Blue Shield Major Medical</td><td>M-None</td></tr><tr><td></td><td>N-United Mine Workers</td></tr><tr><td></td><td>P-Black Lung</td></tr></tbody></table>	A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Champus	B-Part B/Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parent's Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung	<p>_____ Signature</p>
A-Part A, Medicare Only	F-Private Medical Insurance																		
R-Part A, Medicare Premium Paid	G-Champus																		
B-Part B/Medicare Only	H-Health Maintenance Organization																		
C-Both Parts A & B Medicare	J-Unknown																		
S-Both Parts A & B Medicare Premium Paid	K-Other																		
D-Blue Cross Blue Shield	L-Absent Parent's Insurance																		
E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.</p>																			

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.

MAIL TO: EDS
P.O. BOX 2009
FRANKFORT, KY 40602

APPENDIX VII

CASH REFUND DOCUMENTATION

1. Check Number	2. Check Amount	
3. Provider Name/Number/Address	4. Recipient Name	
	5. Recipient Number	
6. From Date of Service	7. To Date of Service	IS. RA Date
9. Internal Control Number (If several ICNs attach RAs)		
_ _ _ _ _		

Reason for Refund: (Check appropriate blank)

- ☐ a. Payment from other source - Check the category and list name
 ☐ Health Insurance (attach a copy of EOB)
 ☐ Auto Insurance
 ☐ Medicare paid
 Other _____
- ☐ b. Billed in error
- ☐ c. Duplicate payment (attach a copy of both RA's)
 If RA's are paid to 2 different providers specify to which provider
 number the check is to be applied.

- ☐ d. Processing error OR Overpayment
 Explain why _____
- ☐ e. Paid to wrong provider
- ☐ f. Money has been requested - date of the letter _/_/_
 (Attach a copy of letter requesting money)
- ☐ a. Other _____

Contact Name _____ Phone: _____

THIRD PARTY LIABILITY
LEAD **FORM**

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address : _____

'Policy #: _____ Start-Date: _____ End Date: _____

Date Filed with Carrier : _____

'rovider Name : _____ Provider #: _____

Comments: _____

Signature: _____ Date: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-A

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
* From* date is first day of eligibility of this card.
To date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD		Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
FROM: 06 - 01 - 85 TO: 07 - 01 - 85	CASE NUMBER 037 C 000123456					
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601						
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
SEE OTHER SIDE FOR SIGNATURE		MAP 8824 REV 1/88				

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P.
Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

This card certifies that the person(s) listed herein is /are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, apportionment, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Champus |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 206.034 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.
Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance or to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Eligibility period shows dates of eligibility represented by this card. * From: date is first day of eligibility of this card. * To: data is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. Kentucky Medicaid payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the Kentucky Medicaid Program).

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		
ELIGIBLE RECIPIENT & ADDRESS	FROM	PHYSICIAN NAME
	TO	PHYSICIAN PROVIDER NO.
	MEDICAL ASSISTANCE IDENTIFICATION NUMBER	
	SEX CODE	
	INSURANCE	PHARMACY NAME
	DATE OF BIRTH MONTH YEAR	PHARMACY PROVIDER NO.
	CASE NUMBER	
SEE OTHER SIDE FOR SIGNATURE	MAP 520A REV 11/88	

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

PINK CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. Questions regarding scope of services should be directed to the Lock-In Coordinator by calling 502-564-5580.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

A- Part A Medicare Only
R- Part A, Medicare Premium Paid
B- Part B Medicare Only
C- Both Parts A & B Medicare
S- Both Parts A & B Medicare
Premium Paid
D- Blue Cross Blue Shield
E- Blue Cross Blue Shield Major
Medical

F- Private Medical Insurance
G- Charous
H- Health Maintenance Organization
J- Unknown
K- Other
L- Absent Parent's Insurance
M- None
N- United Mine Workers
P- Black Lung

I have read the above information and agree with
the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance (also to report changes relating to eligibility or permits use of the card by an ineligible person).

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Name and provider number of Lock-In physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP).

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES	
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS	
FROM	ELIGIBILITY PERIOD
TO	PHYSICIAN NAME
ELIGIBLE RECIPIENT & ADDRESS	PHYSICIAN PROVIDER NO.
	MEDICAL ASSISTANCE IDENTIFICATION NUMBER
	SEX CODE
	INSURANCE
	DATE OF BIRTH MONTH YEAR
	PHARMACY NAME
	PHARMACY PROVIDER NO.
	CASE NUMBER

SEE OTHER SIDE FOR SIGNATURE

MAP 930A REV 11/86

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 502-564-5560.

You are hereby notified that under State Law KRS 206.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Charpus |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance failing to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care provider listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Name of members eligible for Kentucky Medicaid. Persons whose names are in this block have the Primary Care provider listed on this card.

Date card was issued

KENPAC MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES				Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD				CASE NUMBER				
FROM: 06-01-90		TO: 07-01-90		037 C 000123456				
CASE NAME AND ADDRESS				KENPAC PROVIDER AND ADDRESS				
ISSUE DATE: 06-27-90 Jane Smith 400 Block Ave. Frankfort, KY 40601				Smith, Jane Smith, Kim 1234567890 2345678912 2 0353 M 2 1284 M				
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS				Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 502-346-9832 PHONE				
SEE OTHER SIDE FOR SIGNATURE				MAP 520K (7/89)				

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care provider.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

GREEN CARD

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDER OF SERVICE	RECIPIENT OF SERVICES																		
<p>This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621</p>	<ol style="list-style-type: none">1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and out-patient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists, optometrists, dental services, obstetrical services, or for other covered services not listed above.2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from physicians community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse anesthetists, and participating providers of dental, hearing, vision, ambulatory, non-emergency transportation, screening, family planning services, and birthing centers.4. Show this card to the person who provides these services to you whenever you receive medical care.5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the first tender and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.6. If you have questions, contact your eligibility worker at the county office.7. Recipient (s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.																		
<p>Insurance Identification</p> <table><tbody><tr><td>A-Part A, Medicare Only</td><td>F-Private Medical Insurance</td></tr><tr><td>R-Part A, Medicare Premium Paid</td><td>G-Champus</td></tr><tr><td>B-Part B Medicare Only</td><td>H-Health Maintenance Organization</td></tr><tr><td>C-Both Parts A & B Medicare</td><td>J-Unknown</td></tr><tr><td>S-Both Parts A & B Medicare Premium Paid</td><td>K-Other</td></tr><tr><td>D-Blue Cross Blue Shield</td><td>L-Absent Parent's Insurance</td></tr><tr><td>E-Blue Cross Blue Shield Major Medical</td><td>M-None</td></tr><tr><td></td><td>N-United Mine Workers</td></tr><tr><td></td><td>P-Black Lung</td></tr></tbody></table>	A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Champus	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parent's Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung	<p>Signature _____</p>
A-Part A, Medicare Only	F-Private Medical Insurance																		
R-Part A, Medicare Premium Paid	G-Champus																		
B-Part B Medicare Only	H-Health Maintenance Organization																		
C-Both Parts A & B Medicare	J-Unknown																		
S-Both Parts A & B Medicare Premium Paid	K-Other																		
D-Blue Cross Blue Shield	L-Absent Parent's Insurance																		
E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>																			

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD FROM: 08-01-85 TO: 07-01-86 CASE NUMBER 037 C 000123456		Smith, Jane Smith, Kim	1234567890 2345678912	2	0353	M
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601				2	1284	M
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		KENPAC PROVIDER AND ADDRESS Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 502-346-9832 PHONE				
SEE OTHER SIDE FOR SIGNATURE		MAP BOOK (7/86)				

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDER OF SERVICE	RECIPIENT OF SERVICES														
<p>This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621</p>	<p>1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital inpatient and outpatient, home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, and rural health center. Authorization by the primary provider is not required for services provided by speech therapists or social workers or social workers (psychiatric), for behavioral services provided by an education or psychologist, or for other covered services not listed above.</p> <p>2. In the event of an emergency, payment can be made to a participating medical provider rendering services to the person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side.</p> <p>3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from physicians, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse anesthetists, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.</p> <p>4. Show this card to the person who provides these services to you whenever you receive medical care.</p> <p>5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>6. If you have questions about your eligibility status as the designated recipient.</p> <p>7. Recipients not temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.</p> <p>Signature _____</p>														
<p>Insurance Identification</p> <table border="0"> <tr> <td>A—Part A, Medicare Only</td> <td>G—Champus</td> </tr> <tr> <td>B—Part B, Medicare Only</td> <td>H—Health Maintenance Organization</td> </tr> <tr> <td>C—Both Parts A & B Medicare</td> <td>J—Other and / or Unknown</td> </tr> <tr> <td>D—Blue Cross / Blue Shield</td> <td>L—Absent Parent's Insurance</td> </tr> <tr> <td>E—Blue Cross / Blue Shield Major Medical</td> <td>M—None</td> </tr> <tr> <td>F—Private Medical Insurance</td> <td>N—United Mine Workers</td> </tr> <tr> <td></td> <td>P—Black Lung</td> </tr> </table>	A—Part A, Medicare Only	G—Champus	B—Part B, Medicare Only	H—Health Maintenance Organization	C—Both Parts A & B Medicare	J—Other and / or Unknown	D—Blue Cross / Blue Shield	L—Absent Parent's Insurance	E—Blue Cross / Blue Shield Major Medical	M—None	F—Private Medical Insurance	N—United Mine Workers		P—Black Lung	<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 206.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>
A—Part A, Medicare Only	G—Champus														
B—Part B, Medicare Only	H—Health Maintenance Organization														
C—Both Parts A & B Medicare	J—Other and / or Unknown														
D—Blue Cross / Blue Shield	L—Absent Parent's Insurance														
E—Blue Cross / Blue Shield Major Medical	M—None														
F—Private Medical Insurance	N—United Mine Workers														
	P—Black Lung														

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(FROM OF CARD)

Red **Blue**

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Eligibility period is the month, day and year of QMB eligibility represented by this card.
"From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Insurance Code indicates type of insurance coverage.

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO:
Jane Smith 400 Block Ave. Frankfort, KY 40601	FROM:	★ MEDICARE PART A PREMIUMS ★ MEDICARE PART B PREMIUMS ★ MEDICARE CO-INSURANCE ★ MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION
	TO:	
	MEDICAID QMB ID. NO.	
	SEX CODE	
	INSURANCE ID.	
ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE	DATE OF BIRTH MONTH YEAR	PLEASE SIGN IMMEDIATELY

MAP 520-C REV (8-88)

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

RED, WHITE, AND BLUE CARD

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES																		
<p>1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductibles only.</p> <p>2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p style="text-align: center;">Cabinet for Human Resources Department for Medicaid Services 275 East Main Street Frankfort, KY 40621-0001</p>	<p>1. Show this card whenever you receive Medical Care.</p> <p>2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.</p> <p>3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>4. If you have questions, contact your case worker at the Department for Social Insurance County office.</p>																		
<p style="text-align: center;">Insurance Identification</p> <table border="0"><tbody><tr><td>A-Part A, Medicare Only</td><td>F-Private Medical Insurance</td></tr><tr><td>R-Part A, Medicare Premium Paid</td><td>G-Champus</td></tr><tr><td>B-Part B Medicare Only</td><td>H-Health Maintenance Organization</td></tr><tr><td>C-Both Parts A & B Medicare</td><td>J-Unknown</td></tr><tr><td>S-Both Parts A & B Medicare Premium Paid</td><td>K-Other</td></tr><tr><td>D-Blue Cross Blue Shield</td><td>L-Absent Parents Insurance</td></tr><tr><td>E-Blue Cross Blue Shield Major Medical</td><td>M-None</td></tr><tr><td></td><td>N-United Mine Workers</td></tr><tr><td></td><td>P-Black Lung</td></tr></tbody></table>	A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Champus	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parents Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung	
A-Part A, Medicare Only	F-Private Medical Insurance																		
R-Part A, Medicare Premium Paid	G-Champus																		
B-Part B Medicare Only	H-Health Maintenance Organization																		
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D-Blue Cross Blue Shield	L-Absent Parents Insurance																		
E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 208.254, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>																			

COMMUNITY MENTAL HEALTH PROCEDURE CODES

Abbreviations

PSY - Psychiatrist
PSYCH - Psychologist
PSY N - Psychiatric Nurse
MSW - Master Social Worker
PE - Professional Equivalent
MHA - Mental Health Associate

Code Type of Professional

1	Psychiatrist
2	Psychologist
4	Psychiatric Nurse
5	Master Social Worker
6	Professional Equivalent
7	M.D.
8	Mental Health Associate

NOTE: In field 24 D of the HCFA (12/90) claim form, you shall enter a five (5) digit procedure code followed by the appropriate one (1) digit code for the type of professional providing the service and then a four (4) digit employee identifying code, which specifically identifies the employee who provided the service.

Example: X0150	1	0021
(Procedure Code)	(Type of Professional)	(Employee Identifier)

It shall be the provider's responsibility to maintain, on-file, the list of employee identifying codes. This list shall be kept updated and available at all times to the Cabinet for Human Resources personnel for reviewing and copying.

COMMUNITY MENTAL HEALTH PROCEDURE CODES

PSYCHIATRIST

- X0110 Psychiatrist - Inpatient Follow-up
- X0111 Psychiatrist - Inpatient Initial
- X0120 Psychiatrist - Adult Therapeutic Rehabilitation
- X0121 Psychiatrist - Children's Therapeutic Rehabilitation (Limited to Under Age 21)
- X0130 Psychiatrist - Personal Care Home
- X0140 Psychiatrist - Emergency
- X0150 Psychiatrist - Outpatient/Individual Therapy
- X0151 Psychiatrist - Outpatient/Group Therapy
- X0152 Psychiatrist - Outpatient/Psychiatric Evaluation
- X0153 Psychiatrist - **Outpatient/Physical** Exam
- X0155 Psychiatrist - Outpatient/Detoxification Unit
- X0156 Psychiatrist - Outpatient/which includes Chemotherapy
- X0157 Psychiatrist - Outpatient/Family Therapy
- X0158 Psychiatrist - **Outpatient/Collateral** Services (Limited to Under Age 21)
- X1159 Psychiatrist - Intensive In-Home (Limited to Under Age 21)

M.D. SUPERVISED BY PSYCHIATRIST

- X0730 M.D. - Personal Care Home/Physical Examination
- X0740 M.D. - Emergency
- X0753 M.D. - Outpatient/Physical Exam
- X0756 M.D. - Outpatient/with Chemotherapy

COMMUNITY MENTAL HEALTH PROCEDURE CODES

ALL OTHER MENTAL HEALTH PROFESSIONALS

- x0010 Other Professional - Inpatient Follow-up Visit (Except MHAs)
- x0020 Other Professional - Adult's Therapeutic Rehabilitation
- x0021 Other Professional - Children's Therapeutic Rehabilitation
- x0030 Other Professional - Personal Care Home (Except MHAs)
- x0040 Other Professional - Emergency
- x0050 Other Professional - Outpatient/Individual Therapy
- x0051 Other Professional - Outpatient/Group Therapy
- x0054 Other Professional - Outpatient/Psychological Exam (Psychologist Only)
- x0057 Other Professional - Outpatient/Family Therapy
- X0058 Other Professional - Outpatient/Collateral Services
(Limited to Under Age- 21)
- X0059 Other Professional - Outpatient/Intensive In-Home
(Limited to Under Age 21)
- X0060 Other Professional - Home Visits

PROFESSIONAL EQUIVALENT

Medicaid reimbursement can be made for the services provided by individuals determined by the Community Mental Health Center and confirmed by the Department for Medicaid Services to have professional education and experience equivalent to the four principal disciplines.

I. Definition

"Individuals with equivalent professional education" are persons who by virtue of education, professional training and experience in the provision or delivery of direct mental health services of the type reimbursable by Medicaid are shown (to the satisfaction of the Department) to be qualified to provide mental health services.

II Documentation

A mental health center desiring to secure reimbursement for services provided by an individual with equivalent professional education shall submit the following data to determine whether the individual does have equivalent professional education:

- A. The individual's name, address, employer, date of employment, current job title, and a summary of the individual's current duties. The applicant shall be employed by your agency for not less than six months while providing Medicaid covered services.
- B. A legible copy of an official transcript of the individual's undergraduate and graduate education upon which the mental health center is relying to establish that the individual has equivalent professional education. To this should be added information regarding the professional licensure or certification status of the individual;
- C. A letter of recommendation from the applicant's immediate supervisor.
- D. A completed CMHC covered services form. See page 4 of this Appendix. Case Management is not a covered service by the CMHC program and therefore that experience shall not be counted towards professional equivalency.
- E. Other information which the mental health center wishes the Department for Medicaid Services to consider when making the determination.

PROFESSI ONAL EQUI VALENT

- F. Clarifying information requested of the mental health center by the Department for Medicaid Services.

III. Criteria

- A. The center shall apply the following criteria to the information obtained and determine whether the individual has equivalent professional education. The center may determine that the individual has equivalent professional education only when the following conditions exist with regard to the individual whose qualifications are at issue; the individual has the following degree, and has for the specified period of time demonstrated professional competence in the provision of mental health services in a supervised setting:
1. BA, identical field, 3 years full-time equivalent supervised experience;
 2. Master's degree, identical field, 6 months full-time equivalent supervised experience;
 3. Doctorate degree, identical field.

An identical field shall be defined as a Bachelor's degree in psychology, sociology, social work, or human services as determined by the Professional Equivalency Review Committee. A master's degree or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.

PROFESSIONAL EQUIVALENT

- B. When determining whether "the individual has demonstrated professional competence in the provision of mental health services," the center shall consider such factors as: supervisory job evaluations; amount of job responsibility; disciplinary action taken by the mental health center against the individual; and such other matters as may show that the individual has provided mental health services in a competent and professional manner.

Nothing in these criteria shall be construed to negate the specific provisions and limitations contained in 907 KAR 1:044 or 902 KAR 20:091. For example: the individual of equivalent professional education cannot be reimbursed for non-covered services, or services payable only when performed by a psychiatrist or clinical psychologist.

IV. Application for Professional Equivalency Determination

The center shall submit to the Department for Medicaid Services all information on which the decision regarding equivalency has been made, and is requested to summarize the most essential points considered in determining the equivalency status. The Department for Medicaid Services shall provide to the mental health center a confirmation of the decision as to each individual for whom the center has requested status as an "individual with equivalent professional education: without undue delay." The Department shall specify the beginning date on which the center may begin receiving reimbursement for the individual determined to have equivalent professional education. The beginning date shall be not later than the month of the request for the confirmation of equivalency if the individual met the qualifications in or prior to that month. Change of employment from one community mental health center to another community mental health center does not necessitate that reconfirmation be granted by the Department for Medicaid Services, only that the Department-for Medicaid Services, be provided notification of the change in employment.

If a decision is made that the individual does not have equivalent professional education, the Department shall state clearly its reasons for the decision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX IV

PROFESSIONAL EQUIVALENT

CMHC COVERED SERVICES		
OUTPATIENT SERVICE	PERCENT OF TIME EACH SERVICE	SUPERVISED BY
Therapeutic Rehabilitation	<hr/>	<hr/>
Individual Therapy	<hr/>	<hr/>
Group Therapy	<hr/>	<hr/>
Family Therapy	<hr/>	<hr/>
Collateral Therapy	<hr/>	<hr/>
Intensive In-Home Services	<hr/>	<hr/>
TOTAL	<hr/>	

SIGNATURE AND TITLE OF PERSON REQUESTING PROFESSIONAL EQUIVALENCY

Signature

Title

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

- (a) name;
- (b) ownership;
- (c) licensure/certification/regulation status; or
- (d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

MAP-343 (Rev. 5/86)

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19____, with conditional termination on _____, 19____, and shall automatically terminate on _____, 19____, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICESBY: _____
Signature of Authorized OfficialBY: _____
Signature of Authorized Official

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State Plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(6) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

AP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____
(Name) _____ (County)
2. _____
(Location Address, Street, Route No, P.O. Box)
3. _____
(City) _____ (State) _____ (Zip)
4. _____
(Office Phone# of Provider)
5. _____
(Pay to, In care of, Attention, etc. If different from above address,)
6. _____
Pay to address (If different from above)
7. Federal Employee ID No, _____
8. Social Security No. _____
9. License No. _____
10. Licensing Board (If applicable): _____
11. Original license date: _____
12. Kentucky Medicaid Provider No. (If known) _____
13. Medicare Provider No. (If applicable) _____
14. Practice Organization/Structure: (1) Corporation
 _____ (2) Partnership _____ (3) Individual
 _____ (4) Sole Proprietorship _____ (5) Public Service Corporation
 _____ (6) Estate/Trust _____ (7) Government/Non-Profit
15. Are you a hospital based physician (salaried or under contract
 by a hospital)? yes _____ no _____
 Name of hospital (s) _____

n

16. If group practice, number of providers in group (specify provider type):

17. If corporation, name, address, and telephone number of corporate office:

Telephone No: _____

Name and address of officers:

18. If partnership, name and address of partners:

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:

Federal _____ State _____ County _____ City _____

-- Charitable or religious

Proprietary (Privately-owned) _____ Other _____

23. Fiscal Year End: _____
24. Administrator : _____ Telephone No. _____
25. Assistant Admin: _____ Telephone No. _____
26. Controller: _____ Telephone No. _____
27. Independent Accountant or CPA: _____
Telephone No. _____
28. If sole proprietorship, name, address, and telephone number of owner:

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board: _____

Member: _____
Member: _____
30. Management Firm (If applicable): _____
31. Lessor (If applicable): _____
32. Distribution of beds in facility:
- | | Total Licensed
Beds | Total Kentucky
Medicaid
Certified Beds |
|----------------------|------------------------|--|
| Acute Care Hospital | _____ | _____ |
| Psychiatric Hospital | _____ | _____ |
| Nursing Facility | _____ | _____ |
| MR/DD | _____ | _____ |
33. NF or MR/DD owners with 5% or more ownership:
- | Name | Address | % of Ownership |
|-------|---------|----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

34. Institutional Review Committee Members (If applicable):

35. Providers of Transportation Services:

Number of Ambulances in Operation: _____

Number of Wheelchair Vans in Operation: _____

Basic Rate \$ _____ (Includes up to _____ miles)

Per Mile \$ _____ Oxygen \$ _____

Extra Patient \$ _____ Other \$ _____

36. Has this application been completed as the result of a change of ownership of-a previously enrolled Medicaid provider? _____ yes _____ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

Date: _____ Staff: _____

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 05/20/92

APPENDIX IX, PAGE 3

RA NUMBER

PROVIDER NAME

RA SEQ NUMBER 8

PROVIDER NUMBER

CLAIM TYPE: PROFESSIONAL SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	2000000000	9892137-301-440	111791	32.00	110
574632	MITCHELL J	4000000000	9892137-301-450	111791	24.00	110

CLAIMS PENDING IN THIS CATEGORY: 2

TOTAL BILLED: 56.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 05/20/92

APPENDIX IX, PAGE 4

RA NUMBER

PROVIDER NAME

RA SEQ NUMBER 8

PROVIDER NUMBER

CLAIM TYPE: PROFESSIONAL SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	EOB
324789	SMITH	4000000000	9892137-301-040	110491	000

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 05/20/92

APPENDIX IX, PAGE 1

RA NUMBER

PROVIDER NAME

RA SEQ NUMBER 2

PROVIDER NUMBER

CLAIM TYPE: PROFESSIONAL SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSQN R	30000000000	9892137-301-410	111791	50.00	2.00	0.00	48.00	365
01 PS 3	PROC X0550	QTY 5		111791	30.00	0.00		30.00	061
02 PS 3	PROC X0650	QTY 5		111791	20.00			18.00	365

CLAIMS PAID IN THIS CATEGORY: 1

TOTAL BILLED: 50.00

TOTAL PAID: 48.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 05/20/92

APPENDIX IX, PAGE 2

RA NUMBER

PROVIDER NAME

RA SEQ NUMBER 8

PROVIDER NUMBER

CLAIM TYPE: PROFESSIONAL SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT N A M E	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
023105	JONES R	40000000000	9892137-301-010	111791	30.00	
01 PCS 6	PROCEDURE	X0450 QTY		111791	30.00	262

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

TRANSMITTAL #13

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 05/20/92

APPENDIX IX, PAGE 5

RA NUMBER

PROVIDER NAME

RA SEQ NUMBER 8

PROVIDER NUMBER

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY CHECK NUMBER 3286364

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	48.00	0.00	48.00	0.00	48.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061 PAID IN FULL BY MEDICAID

110 CLAIM SUSPENDED FOR REVIEW

262 RECIPIENT IS NOT ELIGIBLE ON THE DATE OF SERVICE

365 FEE ADJUSTED TO MAXIMUM ALLOWABLE